DIVISION OF CHILD MENTAL HEALTH SERVICES
REQUEST FOR RE-AUTHORIZATION OF TREATMENT
OUTPATIENT SERVICES

Client Name _____DOB:_____Admission Date _____

Facility/Program_____ Current Diagnosis: _____

Attach proposed treatment plan for next authorization period.

Total Number of sessions scheduled this authorization period _____

Number of sessions cancelled within 24 hours by family _____

Number of sessions cancelled by therapist _____

Number of No Shows by Client/Family _____

Summary of Treatment Since Last Authorization/Re-Authorization

Reference problems listed on Admission Form. (These should be consistent with treatment Plan)

Mention medication if this service is also being provided.

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Describe client/family response to present treatment modality. Explain, e.g., poor attendance, failure to follow up on action plans, finding b-mod useful, etc. If client/family is not responsive, what efforts will be made to engage the family/client or to encourage treatment progress?

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Number of sessions being requested (up to 20) _____

Period of authorization requested (up to one year) _____

Therapist Signature _____Date_____